TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Southwest Center Medical

Respondent Name
Protective Insurance Co

MFDR Tracking Number
M4-15-4124-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
August 21, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our billing and reports are all correct wit this type of testing done."

Amount in Dispute: $353.81

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent's denial of the medical bills should be upheld."

Response Submitted by: Downs Stanford, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 7, 2014 November 3, 2014	992123, 99080 -73 97750 – GP	$134.13 $219.68	$172.07

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §129.5 sets out guidelines for work status reports.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B20 – Service partially/fully furnished by another provider
   - Required modifier missing or inconsistent w/proced
   - 4 – Required modifier missing or inconsistent w/proced
   - GP – Service delivered under OP PT care plan

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Was the correct code/modifier code used for services in dispute?
3. What is the applicable rule that pertains to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code B20 – "Service partially/fully furnished by another provider" for services in dispute from October 7, 2014 and 4 – "Required modifier missing or inconsistent w/proced" for services in dispute from November 3, 2014."

   Review of the submitted information finds:

   a. The services submitted on October 7, 2014 were;

      i. 99213 – Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family

      ii. 99080 -73 – Special Reports

   28 Texas Administrative Code §134.203 (b) states,

   For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

   (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

   Per CMS, Medicare Learning Network, (MLN)Matters®Number: SE1419, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1419.pdf "Medicare requires that services provided/ordered be authenticated by the author. The method used should be a handwritten or electronic signature. Under certain circumstances, a rubber stamped signature is acceptable."

   The "Physician Record" with date 10/7/14 finds insufficient information to support the name and signature of the health care professional who conducted the assessment. The "Texas Workers Compensation Work Status Report" section "5" lists, Dr. Ed Wolski, MD. The medical bill lists, Charles Willis, MD, NPI 1336142983 as "Rendering Provider".

   The insurance carrier's denial reason is supported as detailed above. Additional reimbursement cannot be recommended.

2. The carrier denied the disputed service 97750 as 4 – "Required Modifier Missing or Inconsistent w/proced and GP – Service deliver under OP PT care plan. 28 Texas Administrative Code 134.203(b) (shown above) requires that for coding, billing and report, system participants shall follow Medicare payment policies, including modifiers. Per CMS, MLN Matters® Number: SE1307 Evaluative Procedures, "As described in the "Required Reporting of Functional Codes" subsection, Functional Reporting is always required when a HCPCS/CPT evaluation or re-evaluation code is reported on a DOS. These HCPCS/CPT codes are listed below: Evaluation/Re-evaluation Codes 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004."

Review of the submitted code in dispute "97750" finds;

a. The description of the service in dispute is, "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes."
b. This code does not require a "Functional Code" modifier per CMS billing and coding guidelines
c. Document titled "Physical Testing" that is dated November 3, 2014. The narrative description of the dispute service is, "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes."

The carrier's denial of this service in dispute is not supported and will therefore be reviewed per applicable rules and fee guidelines.

3. 28 Texas Administrative Code 134.203 (c) states, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service conversion factor)." The eligible service in dispute will be calculated as follows:

   - Procedure code 97750, service date November 3, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 0.4563. The practice expense (PE) RVU of 0.46 multiplied by the PE GPCI of 1.013 is 0.46598. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.803 is 0.02409. The sum of 0.94637 is multiplied by the Division conversion factor of $55.75 for a MAR of $52.76. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $52.76. The PE reduced rate is $39.77 at 3 units is $119.31. The total is $172.07.

4. The total allowable reimbursement for the services in dispute is $172.07. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $172.07. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $172.07.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $172.07 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		September , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.